Alzheimer's Service Center
6701 Highway 85, Riverdale, Georgia 30274
(770) 603-4090 Fax (770) 603-4092

MEDICAL EXAMINATION
(To be completed by physician)

Date ____ / ____ / ____

Name of Patient _____ Date of Birth ____ / ____ / ____

Address _____ Zip Code _____

_____

Telephone _____

Diagnosis of Alzheimer's Disease ? Yes [ ] No [ ] Date of Diagnosis ____ / ____ / ____

Other Diagnoses, Medical Problems or Impairments? _____

_____

_____

Please list ALL medications patient is receiving. (You will be asked to sign a consent for medication to be given during services hours.)

Medication	Dosage	Frequency

Any Special Treatments or Considerations? _____

_____

Any Dietary Restrictions? _____

_____

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Any Restrictions on Physical Activity? _____

_____

Present: TPR _____ BP _____ Allergies _____

TB Test Results or Current Chest X-Ray Date (Please note: Certification of a negative TB test or Chest X-Ray within past 3 months is required)_____
_____

Has patient been given Mini-Mental Status Test? Yes [ ] No [ ] If Yes, Total Score _____

Date of Last Examination ____ / ____ / ____

Additional Comments and Recommendations

_____

_____

_____

_____

Physician Name_____

Signature _____ Date ____ / ____ / ____

Address _____ Zip Code _____

_____

Telephone _____